



Thank you for selecting our dental healthcare team!
 We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card (Visa, MC, Discover)

0% Financing with credit approval I wish to discuss the office's payment policy.

Account/Dental Insurance Information

Name of Person Responsible for this Account _____ Relationship to Patient _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking? _____
4. Do you use tobacco products? Yes No
5. Do you use controlled substances? Yes No
6. Are you allergic to or have you had any reactions to the following? Yes No
- Local Anesthetics (e.g. Novocain) Yes No
 - Penicillin or any other Antibiotics Yes No
 - Sulfa Drugs Yes No
 - Tetracycline Yes No
 - Sedatives Yes No
 - Iodine Yes No
 - Aspirin Yes No
 - Any Metals (e.g. nickel, mercury, etc.) Yes No
 - Latex Rubber Yes No
 - Household Bleach Yes No
 - Other (please list) _____ Yes No
7. **Women Only:**
- a) Are you pregnant or think you may be? Yes No
 - b) Are you nursing? Yes No
 - c) Are you taking oral contraceptives? Yes No

8. Do you take or have you taken any of the following?
- | | | |
|--|--|---|
| Pre-Medication..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fosomax <input type="checkbox"/> Yes <input type="checkbox"/> No | Vitamins..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Thinners..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Boniva/Actonel..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Supplements..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Do you have or have you had any of the following?
- | | | |
|---|--|---|
| *Heart Conditions Yes No | Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Convulsions..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease/Bladder Trouble... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| *Respiratory Problems Yes No | Sexually Transmitted Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV or AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequently Tired..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis/Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hayfever/Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Problems/Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet/sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw?
- Clicking..... Yes No
 - Pain (joint, ear, side of face)..... Yes No
 - Difficulty in opening or closing..... Yes No
 - Difficulty in chewing..... Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you ever had any prolonged bleeding following extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
If so, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
16. Do you like your smile? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that I am ultimately responsible for charges incurred on my behalf and that I will pay regardless of what the insurance company does not. I agree to pay a service charge of 1-1/2% per month on amounts deemed past due. I also agree that should my account be deemed delinquent, I will pay for reasonable collection costs/attorney fees. I understand that Advanced Dental Care follows HIPAA guidelines and regulations involving my treatment and care.

X _____
Signature of patient (or parent/guardian)